FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031971

Facility Name: GREENWOOD CARE LTD.

Address: 1406 N. CHICAGO AVE. (Number) EVANSTON (City) 60201 (Zip Code)

County: COOK

Telephone Number: (847) 328-7508 **Fax #** (847) 869-4878

IDPA ID Number: 363487508001

Date of Initial License for Current Owners: 01/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,610	422		49,032	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,610	422		49,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.64%

D. How many bed-hold days during this year were paid by Public Aid?
1,906 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,273	13,875	24,396	172,544		172,544	(14,078)	158,466			1
2	Food Purchase		176,133		176,133	(14,053)	162,081	(15)	162,065			2
3	Housekeeping	132,623	23,665		156,288		156,288	517	156,805			3
4	Laundry		13,897	13,866	27,763		27,763		27,763			4
5	Heat and Other Utilities			88,719	88,719		88,719	1,623	90,342			5
6	Maintenance	41,354	14,700	102,467	158,521		158,521	(24,972)	133,549			6
7	Other (specify):*							6,447	6,447			7
8	**TOTAL General Services**	308,250	242,270	229,448	779,968	(14,053)	765,916	(30,478)	735,437			8
	B. Health Care and Programs											
9	Medical Director			2,700	2,700		2,700		2,700			9
10	Nursing and Medical Records	830,439	16,124	82,720	929,283		929,283	(14,566)	914,717			10
10a	Therapy			15,516	15,516		15,516	(3,449)	12,067			10a
11	Activities	126,563	10,433	1,225	138,221		138,221		138,221			11
12	Social Services	200,211			200,211		200,211		200,211			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,129	5,129			15
16	**TOTAL Health Care and Programs**	1,157,213	26,557	102,161	1,285,931		1,285,931	(12,886)	1,273,045			16
	C. General Administration											
17	Administrative	86,763		372,242	459,005		459,005	(284,086)	174,919			17
18	Directors Fees											18
19	Professional Services			133,991	133,991	(195)	133,796	(84,276)	49,520			19
20	Dues, Fees, Subscriptions & Promotions			28,025	28,025		28,025	(8,865)	19,160			20
21	Clerical & General Office Expenses	88,005	17,704	36,967	142,676		142,676	35,990	178,666			21
22	Employee Benefits & Payroll Taxes			277,326	277,326	14,053	291,379		291,379			22
23	Inservice Training & Education											23
24	Travel and Seminar			656	656		656	195	851			24
25	Other Admin. Staff Transportation			1,348	1,348		1,348	1,976	3,324			25
26	Insurance-Prop.Liab.Malpractice			76,817	76,817		76,817	849	77,666			26
27	Other (specify):*							23,031	23,031			27
28	**TOTAL General Administration**	174,768	17,704	927,372	1,119,844	13,857	1,133,701	(315,185)	818,516			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,640,231	286,531	1,258,981	3,185,743	(195)	3,185,548	(358,549)	2,826,998			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GREENWOOD CARE LTD. #0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,152	67,152		67,152	111,749	178,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,427	2,427		2,427	349,701	352,128			32
33	Real Estate Taxes			108,540	108,540	195	108,735	4,404	113,139			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			14,191	14,191		14,191	5,771	19,962			35
36	Other (specify):*							8,459	8,459			36
37	**TOTAL Ownership**			668,590	668,590	195	668,785	3,804	672,589			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,388	79,388		79,388		79,388			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,640,231	286,531	2,006,959	3,933,721		3,933,721	(354,745)	3,578,976			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,853	30		9
10	Interest and Other Investment Income	(4,254)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,495)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,287)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,510)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,131)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,839)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(345,906)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (345,906)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (354,745)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

GREENWOOD CARE LTD.

ID# 0031971

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL Council Cope	$ (2,271)	20	1
2	Theft and Damage	(404)	21	2
3	Non Allowable Legal	(549)	19	3
4	R & M Capitization	(9,183)	06	4
5	Prior Period Legal	(7,369)	19	5
6	Misc. Income-Buidling rent	(763)	21	6
7	Jury Duty	(52)	10	7
8	Contribution-Building Co.	(500)	20	8
9	Architech Fee	(1,040)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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90				90
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(22,131)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(14,078)							(14,078)	1
2	Food Purchase	(15)											(15)	2
3	Housekeeping			517									517	3
4	Laundry													4
5	Heat and Other Utilities			650	973								1,623	5
6	Maintenance	(9,183)		458	(8,215)	(8,032)							(24,972)	6
7	Other (specify):*				738	5,709							6,447	7
8	**TOTAL General Services**	(9,198)		1,625	(6,504)	(16,401)							(30,478)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)			(13,398)			(1,116)					(14,566)	10
10a	Therapy					(3,449)							(3,449)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,175	1,954							5,129	15
16	**TOTAL Health Care and Programs**	(52)			(10,223)	(1,495)		(1,116)					(12,886)	16
	C. General Administration													
17	Administrative			11,958	(44,220)	(248,964)			(2,860)				(284,086)	17
18	Directors Fees													18
19	Professional Services	(8,958)		(72,287)	(8,058)	5,003			24				(84,276)	19
20	Fees, Subscriptions & Promotions	(9,553)	500	160	14				14				(8,865)	20
21	Clerical & General Office Expenses	(8,677)		40,005	4,542				120				35,990	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			32	163								195	24
25	Other Admin. Staff Transportation			469	1,507								1,976	25
26	Insurance-Prop.Liab.Malpractice			351	498								849	26
27	Other (specify):*			7,756	4,369	10,691			215				23,031	27
28	**TOTAL General Administration**	(27,188)	500	(11,556)	(41,185)	(233,270)			(2,487)				(315,185)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,438)	500	(9,931)	(57,912)	(251,166)		(1,116)	(2,487)				(358,549)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	31,853	75,775	1,704	2,417								111,749	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,254)	350,317	867	2,771								349,701	32
33	Real Estate Taxes			1,535	2,869								4,404	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			2,322	3,449								5,771	35
36	Other (specify):*		8,459										8,459	36
37	TOTAL Ownership	27,599	(41,729)	6,428	11,506								3,804	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,839)	(41,229)	(3,503)	(46,406)	(251,166)		(1,116)	(2,487)				(354,745)	45

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACH						
				GREENWOOD		
				CARE LLC	EVANSTON	BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 476,280	Greenwood Care LLC		$	$ (476,280)	1
2	V	32	Interest Income	67	Greenwood Care LLC			(67)	2
3	V								3
4	V	36	Amortization Nomura Fee		Greenwood Care LLC		8,459	8,459	4
5	V	30	Depreciation		Greenwood Care LLC		72,192	72,192	5
6	V	30	Depreciation		Greenwood Care LLC		3,583	3,583	6
7	V	32	Interest		Greenwood Care LLC		350,384	350,384	7
8	V	20	Contribution		Greenwood Care LLC		500	500	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 476,347			$ 435,118	$ * (41,229)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 517	$ 517	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	650	650	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	458	458	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	11,958	11,958	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,853	1,853	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	160	160	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	40,005	40,005	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	32	32	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	469	469	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	351	351	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,756	7,756	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,704	1,704	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	867	867	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,535	1,535	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,322	2,322	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	74,140	PREFERRED BOOKKEEPING	100.00%		(74,140)	32
33	V	19	COMPUTER	3,480	PREFERRED BOOKKEEPING	100.00%	3,480		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,620			$ 74,117	$ * (3,503)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 973	$ 973	15
16	V	6	REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	4,841	(8,215)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	738	738	17
18	V	10	NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	15,318	(13,398)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,175	3,175	19
20	V	17	ADMINISTRATIVE	50,868	S.I.R. MANAGEMENT, INC.	100.00%	6,648	(44,220)	20
21	V	19	PROFESSIONAL FEES	11,748	S.I.R. MANAGEMENT, INC.	100.00%	3,690	(8,058)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	14	14	22
23	V	21	CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	19,338	4,542	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	163	163	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,507	1,507	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	498	498	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,369	4,369	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,417	2,417	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,771	2,771	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,869	2,869	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,449	3,449	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,184			$ 72,778	$ * (46,406)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 14,796	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,840	$ (9,956)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,003	1,003	16
17	V	17	ADMIN./LEGAL SALARIES	305,524	S.I.R. MANAGEMENT, INC.	100.00%	30,331	(275,193)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	10,223	10,223	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	5,177	5,177	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	19,918	19,918	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,197	3,197	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	15,411	15,411	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,317	2,317	25
26	V								26
27	V	10A	SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	9,427	(3,449)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,954	1,954	28
29	V								29
30	V	6	REPAIRS AND MAINT.	25,254	S.I.R. MANAGEMENT, INC.	100.00%	17,222	(8,032)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,570	3,570	31
32	V								32
33	V	1	DIETICIAN SALARIES	9,600	S.I.R. MANAGEMENT, INC.	100.00%	5,478	(4,122)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,136	1,136	34
35	V								35
36	V	19	LEGAL FEES	5,220	S.I.R. MANAGEMENT, INC.	100.00%		(5,220)	36
37	V								37
38	V	17	COUNCIL DUES	9,100	S.I.R. MANAGEMENT, INC.	100.00%		(9,100)	38
39	Total			$ 382,370			$ 131,204	$ * (251,166)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 90,921	$ 90,921	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	90,921	CCS EMPLOYEE BENEFIT GROUP	100.00%		(90,921)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 90,921			$ 90,921	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	XCEL Medical Supply, LLC	100.00%	$	$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	8,241	XCEL Medical Supply, LLC	100.00%	7,125	(1,116)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,241			$ 7,125	$ * (1,116)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 24	$ 24	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	14	14	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	120	120	17
18	V	17	MANAGEMENT FEES	6,500	ECM OWNERS COUNCIL	100.00%		(6,500)	18
19	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	3,640	3,640	19
20	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	215	215	20
21	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,500			$ 4,013	$ * (2,487)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Shareholder	Administrative	4.83%	See Attached	4.2	12.00%	Alloc. SIR	$ 19,918	17-7	1
2	Eric Rothner	Shareholder	Administrative	51.72%	See Attached	0.49	1.00%	Alloc. SIR	1,376	17-7	2
3	Nenita Guzman	Relative	Dietary	0	See Attached	3.9	8.00%	Alloc. SIR	4,840	01-07	3
4	Louise Bergthold	Shareholder	Administrative	3.45%	See Attached	4.29	8.00%	Alloc. SIR	13,899	17-7	4
5	Thomas Winter	Owner	Administrative	3.45%	See Attached	4.74	8.00%	Alloc Pref. BK	11,958	17-7	5
6	Michael Giannini	Shareholder	Administrative	3.45%	See Attached	4.8	12.00%	Alloc SIR/OC	15,411	17-7	6
7	Arturo Rominiquit	Relative	Courier	0	See Attached	2.9	8.00%	Alloc. SIR	1,869	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,271		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	938,058	11	$ 6,541	$	74,140	$ 517	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	938,058	11	8,219		74,140	650	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	938,058	11	5,799		74,140	458	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	938,058	11	151,295	151,295	74,140	11,958	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	938,058	11	23,448		74,140	1,853	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	938,058	11	2,020		74,140	160	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	938,058	11	506,159	442,988	74,140	40,005	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	938,058	11	400		74,140	32	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	938,058	11	5,937		74,140	469	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	938,058	11	4,435		74,140	351	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	938,058	11	98,137		74,140	7,756	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	938,058	11	21,566		74,140	1,704	12
13	32	INTEREST	BOOK./ACCNT.INCOME	938,058	11	10,965		74,140	867	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	938,058	11	19,425		74,140	1,535	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	938,058	11	29,379		74,140	2,322	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						3,480	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,725	$ 594,283		$ 74,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	628,177	10	$ 12,461	$	49,032	$ 973	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	628,177	10	62,016	45,622	49,032	4,841	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	628,177	10	9,458		49,032	738	3
4	10	NURSING	PATIENT DAYS	628,177	10	196,243	196,243	49,032	15,318	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	628,177	10	40,682		49,032	3,175	5
6	17	ADMINISTRATIVE	PATIENT DAYS	628,177	10	85,174	85,174	49,032	6,648	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	628,177	10	47,273		49,032	3,690	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	628,177	10	176		49,032	14	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	628,177	10	247,745	202,804	49,032	19,338	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	628,177	10	2,093		49,032	163	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	628,177	10	19,306		49,032	1,507	11
12	26	INSURANCE	PATIENT DAYS	628,177	10	6,377		49,032	498	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	628,177	10	55,976		49,032	4,369	13
14	30	DEPRECIATION	PATIENT DAYS	628,177	10	30,963		49,032	2,417	14
15	32	INTEREST	PATIENT DAYS	628,177	10	35,501		49,032	2,771	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	628,177	10	36,759		49,032	2,869	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	628,177	10	44,185		49,032	3,449	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 932,388	$ 529,843		$ 72,778	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	$ 62,004	$ 62,004	49,032	$ 4,840	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		49,032	1,003	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	49,032	30,331	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		49,032	10,223	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	$ 66,321	$	49,032	$ 5,177	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	4	19,918	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		4	3,197	8
9						$	$		$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	5	15,411	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		5	2,317	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	$ 60,726	$ 60,726	12,876	$ 9,427	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589		12,876	1,954	14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	25,254	17,222	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		25,254	3,570	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	9,600	5,478	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		9,600	1,136	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,306,658	$ 998,091		$ 131,204	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 90,921	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 90,921	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)3287615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$	1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						7,125	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,125	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	40,000	9	$ 150	$	6,500	$ 24	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	40,000	9	89		6,500	14	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	40,000	9	739		6,500	120	3
4	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	40,000	9			6,500		4
5	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	38	9	29,045	29,045	5	3,640	5
6	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	38	9	1,713		5	215	6
7	17	ADMIN. SALARY	DIRECT ALLOCATION		7	(2,635)				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 29,101	$ 29,045		$ 4,013	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NORMURA		X	MORTGAGE	$35,561.00	03/01/95	$	$ 3,939,725	02/01/21	8.69%	$ 350,384	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Insurance Financing										2,427	6
7												7
8												8
9	TOTAL Facility Related				$35,561.00		$	$ 3,939,725			$ 352,811	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(683)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (683)	14
15	TOTALS (line 9+line14)						$	$ 3,939,725			$ 352,128	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income	X					$	$			$ (4,321)	1
2	Alloc. PREF. BOOK	X									867	2
3	Alloc. SIR MANAGEMENT	X									2,771	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (683)	21

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	133,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	123,744	2
3. Under or (over) accrual (line 2 minus line 1).	$	(10,056)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	123,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	195	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	113,140	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	121,501	8
1998	124,628	9
1999	127,335	10
2000	129,713	11
2001	119,340	12

2002 R/E ACCURAL= $119,340.34*1.03=$123,000

R/E TAX ALLOC S.I.R. $1537.73 & TOTAL ALLOCATION FROM PREF. BOOK $1131.43=$2669.15

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GREENWOOD CARE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steven Lavanda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-34-019-0000	Long Term Care Property	$ 119,340.34	$ 119,340.34
2.	SEE ATTACHED	SEE ATTACHED	$ 48,920.62	$ 2,669.15
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 168,260.96	$ 122,009.49

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GREENWOOD CARE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,467 B. General Construction Type: Exterior BRICK Frame 7 Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY-Greenwood Care LLC		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145			1990	$ 1,845,500	$ 75,775	35	$ 90,024	$ 14,249	$ 180,048	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	1,267	9
10	Various			1987	24,869		20	723	723	12,061	10
11	Various			1988	27,733		20	1,146	1,146	11,999	11
12	Various			1989	21,624		20	1,016	1,016	11,169	12
13	Various			1990	27,300		20	1,365	1,365	18,382	13
14	Various			1991	9,846		20	491	491	6,413	14
15	Various			1992	25,025		20	1,244	1,244	13,791	15
16	Various			1993	63,911		20	3,195	3,195	31,159	16
17	Various			1994	20,319		20	1,017	1,017	8,525	17
18	Various			1995	73,839		20	3,693	3,693	28,033	18
19	Various			1996	109,220		20	5,461	5,461	35,777	19
20	Various			1997	73,171		20	3,658	3,658	20,143	20
21	Various			1998	58,371		20	2,919	2,919	13,072	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		64,584	2,307		2,600	293	19,209	68
69	Financial Statement Depreciation			65,640			(65,640)		69
70	TOTAL (lines 4 thru 69)		$ 2,447,984	$ 143,722		$ 118,628	$ (25,094)	$ 411,048	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,447,984	$ 143,722		$ 118,628	$ (25,094)	$ 411,048	1
2	FIRE DAMPERS	1999	27,200		20	1,360	1,360	4,873	2
3	ELEVATOR WORK	1999	3,215		20	161	161	604	3
4	BOILER	1999	18,800		20	940	940	3,055	4
5	S.I.R. ALLOCATION	1999	8,112		20	406	406	1,320	5
6	CALL SYSTEM	1999	2,294		20	115	115	374	6
7	PAINTING	1999	28,077		20	1,404	1,404	4,329	7
8	FLOORING	1999	1,537		20	77	77	295	8
9	ELEVATOR REPAIR	1999	1,000		20	50	50	179	9
10	CONDENSATE PUMP	1999	1,410		20	71	71	219	10
11	ASBESTOS ABATEMENT	1999	2,940		20	147	147	453	11
12	PAINTING	1999	34,697		20	1,735	1,735	5,350	12
13	PAINTING	1999	45,426		20	2,271	2,271	6,813	13
14	CUBICLE CURTAINS	1999	11,333		20	567	567	1,701	14
15	FLOORING	1999	6,258		20	313	313	939	15
16	FLOORING	2000	30,830		20	1,542	1,542	4,626	16
17	FLOORING	2000	7,498		20	375	375	1,125	17
18	FLOORING	2000	13,842		20	692	692	2,018	18
19	.FLOORING - WALLBASE	2000	3,637		20	182	182	516	19
20	FLOORING	2000			20				20
21	PAINTING	2000	5,667		20	283	283	849	21
22	PAINTING	2000	5,831		20	292	292	876	22
23	BOILER WORKS	2000			20				23
24	TILE WORK	2000	49,747		20	2,487	2,487	6,426	24
25	WINDOW TREATMENT	2000	4,893		20	245	245	653	25
26	PEDESTRIAN DOOR	2000	2,988		20	149	149	323	26
27	BOILER WORK	2000	1,240		20	62	62	181	27
28	BOILER WORK	2000	1,600		20	80	80	227	28
29	TILE WORK	2000	3,700		20	185	185	416	29
30	WINDOW TREATMENTS	2000	1,274		20	64	64	144	30
31	BATHROOM WORK	2000	1,442		20	72	72	162	31
32	TILE WORK	2000	659		20	33	33	99	32
33	WINDOWS	2000	4,192		20	210	210	490	33
34	TOTAL (lines 1 thru 33)		$ 2,779,323	$ 143,722		$ 135,198	$ (8,524)	$ 460,683	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,779,323	$ 143,722		$ 135,198	$ (8,524)	$ 460,683	1
2	FLOORING	2000	5,016		20	251	251	732	2
3	ROOM DIVIDERS	2000	21,761		20	1,088	1,088	2,811	3
4	PHONE LINES	2000	1,128		20	56	56	112	4
5	TILE	2000	569		20	28	28	56	5
6	PLUMBING	2000	1,285		20	64	64	128	6
7	RADIATOR COVERS	2000	540		20	27	27	54	7
8	FRAMES/ROOM SIGNS	2000	1,313		20	66	66	132	8
9	CORAIN TOP	2000	1,224		20	61	61	122	9
10	WALK IN FREEZER	2001	23,597		20	1,180	1,180	1,868	10
11	DOOR SYSTEM	2001	3,255		20	163	163	217	11
12	SEWER WORK	2001	2,409		20	120	120	160	12
13	NEW WINDOWS	2001	4,384		20	219	219	256	13
14	FLOOR TILE - ELEVATO	2001	706		20	35	35	70	14
15	WINDOW TREATMENTS	2001	956		20	48	48	84	15
16	WALK IN COOLER	2001	2,210		20	111	111	185	16
17	REPLACEMENT WINDOWS	2001	4,384		20	219	219	256	17
18	HVAC	2001	1,261		20	63	63	126	18
19	HVAC	2001	1,004		20	50	50	96	19
20	HVAC	2001	1,003		20	50	50	58	20
21	DOOR RESTRICTORS-ELE	2001	3,490		20	175	175	233	21
22	MINI BLINDS	2001	463		20	23	23	29	22
23	CURTAINS	2001	69		20	3	3	4	23
24	TILE	2001	119		20	6	6	7	24
25	TILE	2001	238		20	12	12	14	25
26	COVE BASE	2001	186		20	9	9	11	26
27	MINI BLINDS	2001	280		20	14	14	16	27
28	MINI BLINDS	2001	310		20	16	16	19	28
29	RAILING	2002	1,335		20	122	122	122	29
30	EXIT SIGNS	2002	11,525		20	960	960	960	30
31	IDPH IMPROVEMENT	2002	18,866		20	472	472	472	31
32	IDPH IMPROVEMENT	2002	8,556		20	214	214	214	32
33	FIRE DOOR	2002	1,268		20	58	58	58	33
34	TOTAL (lines 1 thru 33)		$ 2,904,033	$ 143,722		$ 141,181	$ (2,541)	$ 470,365	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,904,033	$ 143,722		$ 141,181	$ (2,541)	$ 470,365	1
2	SEWER WORK	2002	4,200		20	175	175	175	2
3	SEWER WORK	2002	2,481		20	83	83	83	3
4	BOILER WORK	2002	1,621		20	27	27	27	4
5	PAINTING	2002	317		20	24	24	24	5
6	PAINTING	2002	585		20	44	44	44	6
7	PAINTING	2002	1,432		20	131	131	131	7
8	PAINTING	2002	440		20	37	37	37	8
9	ROOM REPAIR	2002	1,025		20	26	26	26	9
10	RADIATOR AND PIPING	2002	1,265		20	127	127	127	10
11	ARCHITECT	2002	1,040		20	9	9	9	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,918,440	$ 143,722		$ 141,864	$ (1,858)	$ 471,048	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc SIR			1993	$ 8,958	$ 249	35	$ 452	$ 203	$ 4,435	4
5	Alloc SIR			1993	20,857	662	35	596	(66)	5,661	5
6	Alloc SIR			1993	11,160	354	35	319	(35)	3,029	6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM S.I.R. MANAGEMENT			1994	28		20	3	3	23	9
10	ALLOCATED FROM S.I.R. MANAGEMENT			1995	205		20	10	10	76	10
11	ALLOCATED FROM S.I.R. MANAGEMENT			1999	973	33	20	49	16	156	11
12	ALLOCATED FROM S.I.R. MANAGEMENT			2000	587	62	20	29	33	79	12
13	ALLOCATED FROM PREFERRED BOOKKEEPING			1997	13,938	312	20	697	385	4,048	13
14	ALLOCATED FROM PREFERRED BOOKKEEPING			1999	111		20	6	6	19	14
15	ALLOCATED FROM PREFERRED BOOKKEEPING			2000	699	-	20	35	35	84	15
16	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			2002	83	-	20	2	2	2	16
17	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1999	2,643	264	20	182	(82)	462	17
18	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1998	1,263	126	20	63	(63)	284	18
19	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1997	79	8	20	4	(4)	26	19
20	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1994	199	5	20	10	5	84	20
21	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1993	338	9	20	17	8	161	21
22	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			2002	44		20	1	1	1	22
23	ALLOCATION FROM S.I.R PROPERTIES PREF. BOOK			1999	1,414	141	20	71	(70)	247	23
24	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1998	676	68	20	34	(34)	152	24
25	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1997	42	4	20	2	(2)	14	25
26	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1994	106	3	20	5	2	45	26
27	ALLOCATION FROM S.I.R PROPERTIES PREF. BOOK			1993	181	7	20	13	6	121	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 64,584	$ 2,307		$ 2,600	$ 359	$ 19,209	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 491,222	$ 1,815	$ 36,608	$ 34,793	10	$ 306,724	71
72	Current Year Purchases	4,689	1,512	430	(1,082)	10	430	72
73	Fully Depreciated Assets	16,307				10	16,307	73
74								74
75	TOTALS	$ 512,218	$ 3,327	$ 37,038	$ 33,711		$ 323,461	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,583,213	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	147,049	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	178,902	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	31,853	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	794,509	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 7,567 Description: LDRY $2100, COPIER $2149,COOLER $1278, ICE MARKER $2040
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2001 CHEVY VAN	$ 551.99	$ 6,624	17
18	Alloc SIR Mangement			3,449	18
19	Alloc Pref. BK			2,322	19
20					20
21	TOTAL		$ 551.99	$ 12,395	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,840	$ 38,001	1
2	Cash-Patient Deposits	9,917	9,917	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	758,501	758,501	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,923	10,923	6
7	Other Prepaid Expenses	775	775	7
8	Accounts Receivable (owners or related parties)	235,000	235,000	8
9	Other(specify): See Supplemental Schedule	51,179	51,179	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,102,135	$ 1,104,296	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	538,200	538,200	15
16	Equipment, at Historical Cost	665,186	884,548	16
17	Accumulated Depreciation (book methods)	(701,214)	(1,767,406)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	3,021	70,806	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 505,193	$ 2,152,765	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,607,328	$ 3,257,061	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,837	$ 73,837	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,243	13,243	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,160	138,160	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,275	8,275	31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,000	123,000	32
33	Accrued Interest Payable		19,971	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,225	7,225	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,331	1,331	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 365,071	$ 385,042	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,939,725	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,939,725	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 365,071	$ 4,324,767	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,242,257	$ (1,067,706)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,607,328	$ 3,257,061	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 941,121	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 941,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	475,136	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(174,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 301,136	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,242,257	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,402,588	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,402,588	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,254	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,015	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,015	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,408,857	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	779,968	31
32	Health Care	1,285,931	32
33	General Administration	1,119,844	33
	B. Capital Expense		
34	Ownership	668,590	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,933,721	40
41	**Income before Income Taxes (line 30 minus line 40)****	475,136	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 475,136	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,949	2,086	$ 48,891	$ 23.44	1
2	Assistant Director of Nursing	1,618	1,762	36,206	20.55	2
3	Registered Nurses	15	15	550	36.72	3
4	Licensed Practical Nurses	13,144	14,029	254,319	18.13	4
5	Nurse Aides & Orderlies	47,899	50,939	447,213	8.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,842	4,165	46,033	11.05	9
10	Activity Assistants	10,826	11,508	80,530	7.00	10
11	Social Service Workers	18,587	19,346	200,211	10.35	11
12	Dietician	1,575	1,738	23,968	13.79	12
13	Food Service Supervisor					13
14	Head Cook	5,035	5,336	40,505	7.59	14
15	Cook Helpers/Assistants	9,879	10,317	69,800	6.77	15
16	Dishwashers					16
17	Maintenance Workers	4,398	4,744	41,354	8.72	17
18	Housekeepers	16,526	17,746	132,623	7.47	18
19	Laundry					19
20	Administrator	1,763	2,086	61,508	29.49	20
21	Assistant Administrator	1,919	2,184	25,255	11.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,647	11,657	88,005	7.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,096	3,347	43,260	12.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	152,719	163,003	$ 1,640,231 *	$ 10.06	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,600	01-03	35
36	Medical Director	Monthly	2,700	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	Monthly	28,716	10-03	38
39	Pharmacist Consultant	Monthly	960	10-03	39
40	Physical Therapy Consultant	60			40
41	Occupational Therapy Consultant	12	2,640	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,225	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Director of Food Services	Monthly	14,796	01-03	47
48	Specialize Rehab	Monthly	12,876	10a-03	48
49	TOTAL (lines 35 - 48)	193	$ 77,641		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	772	$ 40,330	10-03	50
51	Licensed Practical Nurses	233	8,586	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,005	$ 48,916		53

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Del Rychener	Administrator	0	$ 61,508
Carmen Cooper	Assistant Admin	0	25,255
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,763

B. Administrative - Other

Description	Amount
Management Fee See Attach	$ 333,150
Ancillary-Admin	32,592
Extended Care Management - Council Dues	6,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 372,242
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting	$ 12,970
Rieff Schramm & Kanter	Bookkeeping Service	74,140
LTC Solution	Computer System	1,320
Personnel Planner	Unemployment Consultant	1,324
See Attached	Legal	20,280
ProClaim America	Third Party Ins set up fee	185
Rieff Schramm & Kanter	Legal	7,369
Preffered Booking	Computer Support	3,480
Sir Management	Dir. Of Reg. Services	11,748
ICS Solution	Website	136
SAS Contruction	Architech	1,040
Included on page 12E line #10	Adjustment page on page 5a	
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 133,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,506
Unemployment Compensation Insurance	13,285
FICA Taxes	123,337
Employee Health Insurance	67,250
Employee Meals	14,053
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	48,540
Other Benefits	1,878
401 K Contribution	7,530
TOTAL (agree to Schedule V, line 22, col.8)	$ 291,379

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,866
Health Care Worker Background Check	
(Indicate # of checks performed 60)	424
Dues	5,168
License	9,514
Alloc Pref. BK Dues	160
Alloc. SIR MGT Dues	14
Alloc ECM Dues	14
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,160

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	656
Seminar Pref. BK	32
Seminar SIR Management	163
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 851

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $7439**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,343** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,053** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees